COMMONWEALTH OF VIRGINIA
Department of Health

ROBERT B. STROUBE, M.D., M.P.H.
STATE HEALTH COMMISSIONER

DOUGLAS R. HARRIS, J.D.
ADJUDICATION OFFICER

**FINDINGS, DISCUSSION AND RECOMMENDATION
TO THE STATE HEALTH COMMISSIONER
REGARDING CERTIFICATE OF PUBLIC NEED (COPN)
REQUEST NUMBER VA-6729,
NORTHERN VIRGINIA COMMUNITY HOSPITAL
ARLINGTON COUNTY
REPLACEMENT AND RELOCATION OF
AN ACUTE CARE HOSPITAL
THROUGH CONSTRUCTION OF
BROADLANDS REGIONAL MEDICAL CENTER
IN LOUDOUN COUNTY**

A. FINDINGS OF FACT

1. Sections 32.1-102.1 and 32.1-102.3 of the Code of Virginia require that a "project," as defined therein to include, among other things, the "[e]stablishment of a medical care facility," must be approved through issuance of a certificate of public need (COPN or certificate) issued by the State Health Commissioner (Commissioner).

2. Virginia regulation, *viz.*, the State Medical Facilities Plan [SMFP, contained in the Virginia Administrative Code (VAC) at 12 VAC 5-230-10 *et seq*.], adopted by the State Board of Health, contains standards and provisions with which the Commissioner reviews applications for a COPN, such as the present one which seeks authorization to replace and relocate a hospital.

3. Pursuant to Subsection B of Section 32.1-102.7 of the Code of Virginia, the Health Systems Agency of Northern Virginia (HSANV) serves Virginia's Health Planning Region (HPR) II, which is coterminous with Virginia's Planning District (PD) 8 and is often referred to as northern Virginia, by reviewing "projects," as defined in Section 32.1-102.1 of the Code of Virginia, proposed for location within the boundaries of PD 8. Loudoun County lies within PD 8.

4. The present application seeks authorization to replace Northern Virginia Community Hospital (NVCH) and Dominion Hospital through relocation to a 180-bed facility to be constructed and known as Broadlands Regional Medical Center (BRMC).

5. The present application was filed in the same "batch," or review cycle, as three other applications proposing the same or similar services in the same medical service area, or HPR. All four applications are, therefore, "competing applications," as defined in 12 VAC 5-220-10, and have been reviewed together.

6. The applications currently competing with the present application to replace NVCH and Dominion with BRMC are:

(a) COPN Request No. VA-6714, filed by Loudoun Hospital Center (LHC) seeking 32 additional acute care beds at its hospital at a total capital cost of $20.9 million, or $654,219 per bed; and

(b) COPN Request No. VA-6731, filed by Inova Health Care Services, Inc., seeking 40 additional acute care hospital beds to be located in a structure already under construction at Inova Fair Oaks Hospital (IFOH) at a total capital cost of $12.7 million, or $317,665 per bed.

In addition, COPN Request No. VA-6728, filed by Potomac Hospital Corporation of Prince William sought 30 additional acute care beds to be located in a new building at Potomac Hospital and certain facility expansions at a total capital cost of $71.6 million. On November 14, 2002, the Commissioner approved the Potomac Hospital project, which was uncontested.

7. The total capital costs associated with the replacement of NVCH and Dominion with BRMC is $192,463,192, or $1,069,239 per bed, excluding the recent cost incurred by HCA of acquiring NVCH. This latter figure exceeds that of several recently-approved hospital replacements, as discussed in detail in relation to the sixteenth statutory consideration, below. The application includes a statement that the proposed project would be funded through the internal reserves of HCA.

8. The SMFP is substantially unchanged since its adoption in 1992. On January 28, 2003, the Commissioner set aside three provisions of the SMFP, two of which apply to proposals to relocate acute care hospital beds. These provisions are identified below.

9. Through its subsidiaries, HCA, Inc. (HCA), has for several years owned and operated two inpatient facilities in PD 8: Dominion Hospital, a 100-bed psychiatric hospital providing mainly child and adolescent care located in Falls Church, an independent city in eastern Fairfax County; and Reston Hospital Center (RHC), a 127-bed acute care hospital located in western Fairfax County built following the 1984 approval of a proposed relocation of Circle Terrace Hospital. HCA is a for-profit entity, incorporated in Tennessee. HCA owns and operates approximately 200 hospitals and other healthcare facilities in 24 U.S. states, England and Switzerland.

10. In 2000, RHC submitted an application for a COPN to authorize the addition of 60 acute care beds and certain other improvements at RHC.

11. During the review of the proposed project to add 60 beds at RHC, HSANV recommended its approval based on imposition of a condition that new beds at RHC would be "offset by reductions in bed capacity elsewhere in [PD 8]."

12. During the review of this 60-bed project, RHC represented that Northern Virginia Community Hospital (NVCH), a 164-bed acute care hospital in Arlington County then unaffiliated with HCA, was expected to close. HCA contested the "offset" condition suggested by HSANV, maintaining in written argument that "RHC has no unused beds to surrender," and that forcing applicants to purchase failing hospitals is "not sound public policy."

13. Pursuant to COPN No. VA-03561, issued by the Commissioner on March 23, 2001, RHC, received authorization to add 60 beds and to make certain improvements, involving total capital costs of just over $45 million, or $750,766 per bed. These 60 beds are not yet in service. The Commissioner declined to impose the offset condition, noting that "[s]ince RHC is not part of a hospital system that has any unused beds in PD 8, nor has control of beds that it can de-license, this condition cannot be met without additional expense for the proposed project."

14. On May 31, 2002, Northern Virginia Community Hospital, L.L.C., an affiliate of HCA and the owner of NVCH, filed a letter of intent with the Department of Health, as required by 12 VAC 5-220-180, indicating it would be filing an application to "establish[] . . . a general hospital in Loudoun County . . . containing between one hundred eighty (180) and two hundred sixty (260) licensed beds."

15. On June 6, 2002, HCA executed an agreement to acquire NVCH, and on June 21, 2002, HCA announced that the process to acquire NVCH had been completed. HCA apparently paid in "actual consideration," $27,500,000 for NVCH.

16. On July 1, 2002, Northern Virginia Community Hospital, L.L.C., whose ultimate parent corporation is now HCA, Inc., filed the present application. NVCH's 164 beds include 144 acute care beds and 20 adult psychiatric beds. The applicant seeks authorization to relocate NVCH and Dominion Hospital (Dominion), a 100-bed psychiatric facility in eastern Fairfax County, by building "the replacement hospital in Loudoun County," later identified by name as Broadlands Regional Medical Center (BRMC). Healthserv Acquisition, L.L.C. is the sole member of NVCH. Healthtrust Inc. - The Hospital Company is a subsidiary of HCA and is the sole member of Healthserv Acquisition.

17. NVHC and Dominion – the hospitals proposed for relocation by the present application, together provide many health care services. These combined services, which would be relocated, include medical-surgical acute nursing care, medical telemetry, ventilator services, mental health services, intensive care services, surgical services, cardiac care, cardiac catheterization and angioplasty services, emergency services, diagnostic imaging services (including computed tomography (CT) and single photon CT services), minor procedure services, laboratory services, various outpatient services, physical therapy services, pharmacy services and lithotripsy services.

18. If authorized by the Commissioner, BRMC would be a 180-bed, acute-care and psychiatric community hospital located in eastern Loudoun County within five and a half miles of Loudoun Hospital Center (LHC). As proposed, BRMC would have 120 acute care beds and 60 psychiatric beds.

19. During its review of the present application and the three competing applications, DCOPN determined that, using the computational methodologies contained in the SMFP, PD 8 will have a surplus of 155 medical-surgical-pediatric beds and 169 intensive care (ICU) beds in 2007, based on the inventory of existing and approved beds. Using an alternative methodology designed and intended to review the four applications in the most favorable light, DCOPN determined that PD 8 will have a surplus of 103 medical-surgical-pediatric beds and 21 intensive care (ICU) beds in 2007, based on the inventory of existing and approved beds.

20. NVCH has identified a service area for BRMC that is distinct from the service area of NVCH. BRMC's primary service area would consist of Loudoun County, while its secondary service area would be the remainder of PD 8.

21. Three acute care hospitals are within 20 miles of the site proposed for BRMC. These include:

(a) LHC, with 91 operational beds, is about five miles north and has authorization for an additional 42 beds not yet in service. (As noted above, LHC is also seeking a 32-bed expansion in an application that is competing with the present application.);

(b) RHC, with 127 beds, is about 12 miles to the east and has authorization for an additional 60 beds which are not yet in service, as discussed above; and

(c) Inova Fair Oaks Hospital (IFOH), with 151 operational beds, is about 18 miles to the east and has authorization for an additional nine beds not yet in service. (As noted above, IFOH is also seeking a separate 40-bed expansion that is competing with the present application.).

22. NVCH represents that "[i]n the course of due diligence in connection with HCA's acquisition of Northern Virginia Community Hospital, it was determined that the hospital's physical plant must be replaced."

23. NVCH further contends that on-site replacement of NVCH is not feasible. At the IFFC, NVCH offered the testimony of an architectural expert who stated that only five acres are available for development on-site at NVCH. LHC offered the testimony of its own architect, who stated that nine to ten acres are available on the NVCH site, which would accommodate a replacement facility.

24. Recently, the board of supervisors of Loudoun County adopted a plan to restrict development severely in western Loudoun. From 1990 to 2000, the population of Loudoun County increased 96.9 percent to a total of 169,599. Projections for future growth vary. The Loudoun County Department of Economic Development predicts a 2011 population of 310,510, while Claritas,Inc., a national

demographics company, predicts a population that year of 249,653, and the Virginia Employment Commission predicts a population of 206,254.

25. Since 1977, the Commissioner has approved at least six applications to replace and relocate acute care hospitals. In each of those cases, the Commissioner determined whether ". . . the replacement was necessary and . . . [whether] the applicant's proposal was reasonable in scope, in location and in cost." *See* decisions regarding: Mary Immaculate Hospital, June 17, 1977; Johnston-Willis Hospital, December 22, 1977; Commonwealth Hospital, September 14, 1983 (quoted); Circle Terrace Hospital, February 27, 1984; Richmond Memorial Hospital, 1993; and Stuart Circle Hospital, January 28, 2003.

26. The board of directors of HSANV, by a vote of 13 in favor, four opposed with two abstentions, recommends denial of the application to relocate NVCH and Dominion to the BRMC site.

27. By letter dated October 21, 2002, with attachments, the Virginia Department of Health, Division of Certificate of Public Need (DCOPN) – the department's health planning staff – notified NVCH that DCOPN recommends denial of the application.

28. On that same day, the Loudoun Health Care Task Force published its final report, entitled "Health Care in Loudoun County," a report examining the "capacity of Loudoun County's health care community to deliver necessary services to its residents and to identify current and future unmet needs." The task force recommended, among other things, an increase in the total number of inpatient hospital beds located in Loudoun County, based on a "comparative benchmark" finding that Loudoun County has a relatively low ratio of inpatient beds per 1,000 population." Such a benchmark bears no relation to general health planning principles or any applicable methodology for determining the public need for hospital beds within a planning district.

29. During the two-year process of developing this report, the task force did not consult with HSANV – the regional health planning agency "designated . . . to perform the health planning activities set forth in [the COPN statute]," pursuant to Section 32.1-102.1 of the Code of Virginia, or request HSANV's participation in the formulation of the recommendation. HSANV, concerned about the process of developing the report and its substance, states that this report is "so flawed as to undermine and make it irrelevant to a decision as to how many beds should be permitted in Loudoun County."

30. A two-day informal fact-finding conference (IFFC) was convened on November 7 and 8, 2002, in Richmond pursuant to Sections 2.2-4019 and 32.1-201.6 of the Virginia Code to discuss the four applications then competing. NVCH was represented by counsel at this IFFC. A certified transcript of the IFFC was made. The applicants were afforded the opportunity to submit additional written information following the IFFC, and the record in this matter closed on December 27, 2002.

NOTE: The discussion that follows contains some specific findings of fact related to the findings set out above.

B. DISCUSSION

Subsection B of Section 32.1-102.3 of the Code of Virginia requires that, in determining whether a public need for a proposed project has been demonstrated, the State Health Commissioner shall review an application for a certificate of public need (COPN) in relation to the twenty considerations enumerated in that section. The following is a discussion of the application in relation to these considerations.

1. The recommendation and the reasons therefor of the appropriate regional health planning agency.

The board of directors of NVHSA reviewed the project proposed by NVCH at a regular meeting held on October 14, 2002. The Board voted 13 in favor and four opposed, with two abstentions to recommend denial of the request.

As stated in an October 17, 2002, letter from HSANV's executive director, the board of directors of HSANV based its decision on its review of the application, on the October 2, 2002, HSANV staff report on the proposal, on the evidence and testimony presented at the October 8, 2002, public hearing and at the October 14, 2002, meeting of the board. HSANV cited the following reasons, which appear in the October 17 letter, supporting its recommendation:

(i) The development of the proposed hospital would create a substantial surplus of hospital capacity in Loudoun County, with far more beds than would be used for the foreseeable future. That surplus would result in unnecessary costs;

(ii) The child and adolescent psychiatric service provided at Dominion would not be central to northern Virginia, creating substantial access issues;

(iii) If there were two underutilized hospitals in Loudoun County, neither would be able to develop the level of sophisticated and tertiary services that one hospital there could build over time as volume increased, as has been done in Winchester and at Mary Washington Hospital in Fredericksburg;

(iv) If the new NVCH were to meet projected levels of utilization, it is extraordinarily unlikely that Loudoun Hospital Center would be able to survive as an independent entity, with the new hospital doing damage not only to Loudoun Hospital but also to the care to residents of Loudoun County;

(v) Regardless of whether Hospital Corporation of America (HCA) has a right to replace NVCH and Dominion, it does not have a right to relocate them to another service area more than 25 miles away;

(vi) The proposed new hospital would have little effect on access to care in Loudoun as its site will be only about four miles from Loudoun Hospital once a road now under construction is open, which will occur before the new hospital would open;

(vii) The relocation of NVCH would be disruptive to Arlington and residents of adjacent parts of Fairfax County, particularly for emergency services, as well as disruptive to Loudoun County;

(viii) With HCA having a record of high charges and little charity care, there could be negative effects on Loudoun residents, particularly if NVCH became the only hospital in the county, with HCA also operating the nearest hospital in Fairfax County;

(ix) If Loudoun Hospital were to encounter substantial financial difficulties, as would be almost certain if NVCH were relocated to Loudoun, it is questionable whether Loudoun would be able to continue to operate the emergency service to open soon at its Cornwall Street site, thereby again reducing access to care for western Loudoun residents;

(x) If both the NVCH and Loudoun Hospital projects were approved, Loudoun County would have 357 hospital beds, which is more than four times the average of 87 to 88 patients a day getting care in Loudoun last year;

(xi) The percent of Eastern Loudoun residents receiving care in Loudoun has been increasing, which indicates that rather than patients being forced out of Loudoun they are receiving care where they choose or are referred, with more choosing or referred for care locally;

(xii) Large numbers of patients migrate either east or north toward the inner areas of northern Virginia regardless of the local hospital capacity;

(xiii) The experience of western Fairfax, where 45 percent go elsewhere for care despite the availability of Reston and Fair Oaks Hospitals, and more go to Fairfax Hospital than either Reston or Fair Oaks, demonstrates that having two hospitals in an area does not result in low outmigration for care, and, to the extent that it retards development of sophisticated and tertiary services, may actually lead to higher outmigration than with one larger hospital.

(xiv) There are four Northern Virginia hospitals serving significant numbers of Loudoun residents, with some residents of Loudoun County nearer Reston or Fair Oaks than Loudoun Hospital Center, and Fairfax Hospital providing sophisticated and tertiary services, as well as some basic care, to residents of Loudoun, just as it does to residents of other parts of the region;

(xv) There are significant expansions occurring at all four hospitals, with Loudoun opening 42 beds within a few months, Fairfax Hospital adding 177 beds (97 of which are opening now), Reston Hospital adding 60 licensed beds and other beds that are licensed but have not been available, and Fair Oaks is restoring 9 licensed beds and 13 other beds that have been licensed but not available;

(xvi) The expansion authorized for HCA's Reston Hospital Center was predicated to a large extent on its service to nearby residents of Loudoun County;

(xvii) There is evidence of population growth slowing in Loudoun County and elsewhere in northern Virginia, with the Loudoun County Comprehensive Plan being revised to prevent large development in western Loudoun and to limit the extent of development in eastern Loudoun;

(xviii) Northern Virginia is not aging rapidly;

(xix) Eastern Loudoun has the lowest hospital use rate in northern Virginia, which has the lowest hospital use rate among Virginia health planning regions;

(xx) The occupancy of licensed and approved (soon to be opened) beds at Loudoun Hospital Center is well below the 85 percent standard for medical-surgical beds that would allow consideration of a relocated hospital;[1] and

(xxi) The application is not consistent with the [SMFP].

NVCH alleges that HSANV's vote "was not supported by any reasons for denial and may have been affected by irregularities in the HSANV Staff Report, public hearing and Board meeting proceedings." Conflicting testimony regarding these issues was presented at the IFFC by both NVCH and the associate director of HSANV, who attended and organized the public hearing.

The bases for these alleged irregularities involve mainly judgments made by HSANV staff who were faced, at the beginning of the October 8, 2002, public hearing, with an unexpected task of ensuring fairness while parceling out the limited time available so as to allow the many citizens who appeared to speak. In a December 5, 2002, letter the chairman of the HSANV board of directors sought to make an assurance that "the October 17 letter accurately conveys the position of the Board of Directors of [HSANV], which was to recommend denial of the application." That recommendation, and the reasons supporting it, ultimately, constitute the first statutory consideration to go before the Commissioner when he makes a decision whether to grant a COPN.

I have fully reviewed and weighed NVCH's allegations of "irregularities," and hereby specifically

REFERENCE

these allegations for the Commissioner's consideration.

[1] On January 28, 2003, the Commissioner set aside the SMFP standard in the third subitem in subsection B of 12 VAC 5-240-30, upon which this finding is based, as noted below.

2. The relationship of the project to the applicable health plans of the regional health planning agency, the Virginia Health Planning Board and the Board of Health.

A. The guiding principles of the COPN program are set forth in five enumerated items within 12 VAC 5-230-30, as follows.

12 VAC 5-230-30. Guiding principles of public need. The following general principles will be used in guiding the implementation of the Virginia Medical Care facilities Certificate of Public Need (COPN) program and have served as basis for the development of the review criteria and standards for specific medical care facilities and services contained in this document:

1. The COPN program will give preference to medical facility and service development approaches which can document improvement in the cost-effectiveness of health care delivery. Providers should strive to develop new facilities and equipment and use already available facilities and equipment to deliver needed services at the same or higher levels of quality and effectiveness, as demonstrated in patient outcomes, at lower costs;

2. The COPN program will seek to achieve a balance between appropriate levels of availability and access to medical care facilities and services for all the citizens of Virginia and the need to constrain excess facility and service capacity;

3. The COPN program will seek to achieve economies of scale in development and operation, and optimal quality of care, through establishing limits on the development of specialized medical care facilities and services, on a statewide, regional, or planning district basis;

4. The COPN program will give preference to the development and maintenance of needed services which are accessible to every person who can benefit from the services regardless of ability to pay.

5. The COPN program will promote the elimination of excess facility and service capacity. The COPN program will promote the conversion of excess facility and service capacity to meet identified needs. The COPN program will not facilitate the survival of medical care facilities and services which have [been] rendered superfluous by changes in health care delivery and financing.

The proposed replacement of NVCH and Dominion through relocation is not consistent with the first enumerated guiding principle of COPN, insofar as the application has not documented that it would improve the cost-effectiveness of health care delivery. Substantial evidence, discussed below, indicates that construction of BRMC would increase market concentration in the affected service area, as shown by application of the Herfindahl-Hirshman Index (an analytical methodology routinely employed by federal agencies that enforce antitrust laws) and decrease the ability of managed care entities and insurance carriers to negotiate for optimal pricing, thereby creating upward pressure on health care costs in PD 8.

B. Standards and considerations aiding the review of applications proposing general acute care services are set forth in Chapter 240 of the SMFP, *i.e.*, 12 VAC 5-240-10 *et seq*.

12 VAC 5-240-20. Accessibility. Acute care in-patient facility beds should be within 45 minutes average driving time, under normal conditions, of 90 % of the population.

This standard has already been met in PD 8. Any conclusion that a proposed project would not provide a significant improvement in geographic access – the purpose of this standard – does not constitute a finding of inconsistency with this provision.

Notably, HSANV observes that "[t]he principal barrier to health care in Northern Virginia is economic, not distance or travel time. . . [w]ith 11 percent of the . . . population uninsured in early 2001. . . ."

12 VAC 5-240-30. Availability. A. Need for new service.

[Not applicable.]

B. Off-site replacement of existing services. 1. No proposal to replace acute care in-patient beds off-site, to a location not contiguous to the existing site, should be approved unless: (i) off-site replacement is necessary to correct life safety or building code deficiencies; (ii) the population served by the beds to be moved will have reasonable access to the acute care beds at the new site, or the population served by the facility to be moved will generally have comparable access to neighboring acute care facilities~~; and (iii) the beds to be replaced experienced an average annual utilization of 85% for general medical/surgical beds and 65 % for intensive care beds in the relevant reporting period~~.

[NOTE: Pursuant to Subsection A of Section 32.1-102.3 of the Code of Virginia, on January 28, 2003, the State Health Commissioner set aside the language contained in the third subpart to this subsection, as indicated by the text stricken through above, finding that the language is outdated and inadequate.]

NVCH retained the services of Gresham Smith and Partners, an architectural firm, which detailed numerous deficiencies at both NVCH and Dominion in a June 10, 2002, report. The physical plants of NVCH and Dominion are in need of substantial upgrades. The NVCH and Dominion Hospital buildings are over 30 years old and have not undergone any major renovation. NVCH asserts that the "resulting design deficiencies and the deteriorating and aged physical plants have not only resulted in operational inefficiencies, but have also made it increasingly more difficult for NVCH and Dominion Hospital to comply with life safety and building code requirements." The transcript of the IFFC includes considerable testimony regarding the deficiencies at both hospitals. Sufficient evidence is in the record demonstrating a need to renovate or replace both NVCH and Dominion.

Regarding the ability of Arlington residents to maintain reasonable access to acute care services, NVCH predicts that, if its application is approved,

> [t]he population currently served by NVCH will have comparable access to neighboring acute care facilities [*i.e.*, Virginia Hospital Center Arlington and Inova Alexandria Hospital], which will become financially healthier and better able to serve the Arlington community if the BRMC project is approved. The BRMC project proposes to relocate NVCH beds from and [sic] area of over-concentration of acute care beds in the northeast quadrant of PD 8 to Loudoun County, where there are fewer acute care beds. This project will substantially improve and re-balance acute care bed access for residents of PD 8. In fact, relocation of 120 acute care beds from Arlington will still mean that 1.4 beds will be available per 1,000 residents of Arlington County in 2010. This ratio is well above the PD 8 average of 1.1 beds per 1,000 projected for 2010.

NVCH also states that "BRMC will continue to provide accessible mental health services to the same patient population it serves now."

In the DCOPN staff report, the Department's professional health planning staff observes that

> [a]s the Broadlands proposal is to relocate beds approximately 25 miles from their current primary service area, the population currently served by these beds will no longer have access to the beds. However, there are currently 15.41 acute care beds per 1,000 population age 55+ in Arlington County. This is 3.4 beds over the state average and approximately 6 beds over the PD 8 average. If all current requests are approved, [*i.e.*, if, in addition to the approval of Potomac Hospital's application, the applications filed by LHC, NVCH and IFOH were approved] the closure of NVCH will reduce the acute care beds per 1,000 in Arlington County to 10.33, approximately two (2) beds less than the state average and less than one (1) over the PD 8 average. Also*, if all current requests are approved, Loudoun County will have the second highest acute care beds per 1,000 population age 55+ in PD 8*, 6.98 [beds] over the PD 8 average and 4.59 [beds] over the state average. Although these projects may not cause the Arlington area population currently served by NVCH to no longer have comparable access to acute care, *it will overbed Loudoun County* and therefore brings into question the applicant's assertion that this project is the solution to the [supposed] misdistribution of acute care beds in PD 8. [Emphasis added.]

Regardless of the likelihood of the Broadlands proposal to result in an overabundance of acute care beds in Loudoun County and, perhaps, in a redistribution that constitutes a misdistribution, persons currently served by NVCH would maintain comparable access to acute care services offered at neighboring facilities if NVCH were relocated as proposed, although they would not likely seek services at BRMC, proposed for location approximately 25 miles away.

2. The number of beds to be moved off-site must be taken out of service at the existing facility.

NVCH states that "[w]ith the approval of the NVCH Project, and completion of its construction, all beds at NVCH and at Dominion Hospital will be taken out of service at the existing Arlington and Falls Church locations."

3. The off-site replacement of beds should result in a decrease in the licensed bed capacity of the applicant facility(ies) or substantial cost savings, cost avoidance, consolidation of underutilized facilities, or in other ways improve operation efficiency or improvements in the quality of care delivered over that experienced by the applicant facility(ies).

If approved, the replacement and relocation of NVCH (which has 164 beds) and Dominion (which has 100 beds) through construction of BRMC (which would have 180 beds) would, ostensibly, result in a decrease of 84 licensed beds in PD 8 [(164 + 100) – 180 = 84]. The proposal would also result in the net elimination of one hospital. NVCH touts its proposal as the only one in the competing batch that would reduce the number of total beds in PD 8. Upon scrutiny, however, this assertion is more nuanced than it appears.

Together, NVCH and Dominion have 264 beds. Since Dominion's 100 psychiatric beds are contained in a freestanding psychiatric facility, they cannot be readily converted into acute care beds and are not licensed as such. As proposed, BRMC would absorb a relocation of 120 of the 164 acute

care beds at NVCH, ostensibly reducing the inventory of acute care beds in PD 8 by 44, and would absorb a relocation of 60 of the 100 psychiatric beds at Dominion, reducing the inventory of psychiatric beds in PD 8 by 40, as shown in the table below.

The psychiatric beds proposed for BRMC, however, by virtue of their inclusion as a constituent unit within an acute care facility, would be licensed by the Department of Health as acute care beds. They also would carry the ability to be converted into acute care beds in the future. As shown below, implementation of BRMC would, therefore, *increase* the total number of licensed acute care beds in PD 8 by 16, despite the categorical reduction in the number of beds.

Proposed Bed Allocation from NVCH and Dominion,
Net Increase in Acute Care Beds

Hospital	Existing Beds		Beds Proposed for Relocation to BRMC			
	Number	Licensed As (Category)	Number	Licensed As (Category)	Resulting Reduction ( ) to PD 8 Inventory	
					Number	Category
NVCH	164	Acute Care	120	Acute Care	(44)	Acute Care
Dominion	100	Psychiatric	60	Acute Care and Psychiatric*	(40)	Psychiatric
Total Number of Existing Acute Care Beds:	***164***		***Effective Total Number of Proposed Acute Care Beds:***	***180***		

*These beds would be licensed by both the Department of Health and the Department of Mental Health Mental Retardation and Substance Abuse Services, as acute care beds by the former and as psychiatric beds by the latter

NVCH points out that

> . . . the consolidation of two obsolete, underutilized, and operationally inefficient facilities into a single state-of-the-art hospital will result in substantial operational and maintenance cost savings. The new BRMC facility will require 11 fewer FTEs than the continued operation of the two existing facilities, which represents a savings of approximately $600,000 in operating costs each year. Because the new facility will be both operationally and energy efficient, labor cost represents just one example of substantial cost savings under the NVCH Project. . . . [T]he state-of-the-art design of the BRMC will make the most modern health care available to PD 8 residents, including equipment and specially designed facilities for immediate response to potential acts of bio-terrorism.

Replacing an older hospital and an older freestanding psychiatric hospital and consolidating their operations into a newly-constructed hospital designed to meet modern practice and contemporary expectations certainly promises increased efficiency and improvements in quality. Such a proposition is unassailable. But a reduction in the number of psychiatric beds alone does little to affect the inventory of acute care beds, while placing them in an acute care facility, where they can be converted

to acute care purposes, does. Other specific facets of the proposed replacement and relocation weigh against its approval, as discussed elsewhere in this document.

C. Alternative need for the conversion of underutilized licensed bed capacity. For proposals involving a capital expenditure of $1 million or more, and involving the conversion of underutilized licensed bed capacity to either medical/surgical, pediatric or intensive care, consideration will be given to the approval of the project if: (i) there is a projected need for the category of acute inpatient care beds that would result from the conversion; and (ii) it can be reasonably demonstrated that the average annual occupancy of the beds to be converted would reach the standard in subdivision B 1 of this section for the bed category that would result from the conversion, by the first year of operation.

As proposed, construction of BRMC would result in the conversion of four underutilized medical-surgical beds at NVCH into intensive care (ICU) beds at BRMC, and the conversion of 14 underutilized medical-surgical beds into progressive care beds, resulting in a proposed total of 16 ICU beds and 34 progressive care beds at BRMC. The applicant projects the first year's occupancy of these beds to be 64 percent and 67 percent respectively. NVCH bases these projections, in part, on the high level of utilization of ICU beds at LHC, calculated by DCOPN to be 80.9 percent in 2001, and that hospital's competing application, which seeks 12 additional ICU beds, along with 20 additional medical-surgical beds. The overall high utilization of beds at LHC will be decreased, however, when it completes construction of 18 additional medical-surgical beds, approved in February 2002.

The project would result in licensure by the Department of Health of 60 psychiatric beds relocated from Dominion as acute care beds. These beds are not currently licensed as acute care beds and their relocation would result in a total net increase of 16 beds in the PD 8 licensed acute care bed inventory.

D. Computation of the need for general medical/surgical and pediatric beds.

[Full text and computational methodology not set forth.]

Although the Broadlands proposal would, in effect, result in an addition of 16 acute care beds to the PD 8 inventory, NVCH has stated that only 120 of the 180 proposed beds would be devoted to acute care. NVCH contends that this provision of the SMFP is not applicable.

During its review of the present application and the three competing applications, DCOPN determined that, using the computational methodologies contained in this section of the SMFP, PD 8 will have a surplus of 155 medical-surgical-pediatric beds in 2007, based on the inventory of existing and approved beds. Using an alternative methodology designed and intended to review the four applications in the most favorable light, DCOPN determined that PD 8 will have a surplus of 103 medical-surgical-pediatric beds and 21 intensive care (ICU) beds in 2007, based on the inventory of existing and approved beds. No need for additional general medical-surgical or pediatric beds exists in PD 8.

E. Computation of need for distinct pediatric units.

[Not applicable.]

F. Computation of need for intensive care beds.

[Full text and computational methodology not set forth.]

NVCH operates 12 ICU beds. The proposal to construct BRMC involves the relocation of these beds and the conversion of four underutilized medical-surgical beds at NVCH to ICU beds at BRMC, resulting in a total of 16 ICU beds proposed for operation at BRMC. NVCH's proposal, therefore, involves an increase of four ICU beds in PD 8, triggering the applicability of this provision, which contains a computational methodology for predicting the need for additional ICU beds.

In its report, DCOPN initially employed the methodology contained in this provision of the SMFP, which yielded a PD 8 surplus of 169 ICU beds in 2007, based on the current inventory of beds and approved but unbuilt additional beds. DCOPN analyzed the issue further, however, and suggested that the methodology may not accurately gauge the need in PD 8 for ICU beds, due to an empirically-observable increase in ICU patient days that outstripped general population growth (a constituent component of the methodology). Using a more generous alternative method of projecting future ICU patient days, resulting in a figure 24 percent higher than that resulting from application of the SMFP methodology, DCOPN found a surplus of 121 ICU beds in 2007.

Again, DCOPN chose to analyze the issue regarding ICU beds in PD 8 further, based on particular suspicion that the predictive methodology contained in this provision of the SMFP may tend to underestimate the practical need for ICU beds. The methodology rests on an assumption that ICU beds in a planning district are equally accessible to all residents at all times. Actual experience demonstrates, however, that this is not so; a person's need for an ICU bed is, as DCOPN wrote in its report, "urgent, unscheduled and extremely location-sensitive." Therefore, DCOPN concludes,

> the best way to determine an appropriate occupancy standard for ICU beds in a planning district is to apply the Poisson probability model [*i.e.*, the model upon which the SMFP computational methodology is based] to each existing ICU, to determine its target average daily census, and then sum the results across the planning district. A reasonable simplification, that should not significantly affect accuracy, is to apply the Poisson probability model to the average or median size of ICUs in the planning district.
>
> The average size of ICUs in PD 8 is 24 beds. Applying the SMFP's Poisson probability model (above) to a unit of 24 beds yields a target average daily census of 15.0, or a target occupancy ratio of 62%. [T]herefore . . . 62% is the target occupancy ratio that should be applied to determine ICU bed need in PD 8. This compares with a target occupancy ratio of 86% that is implied by the SMFP standard for PD 8's ICU beds, and which is a higher occupancy standard than the SMFP applies to general medical-surgical beds.

In applying this more sensitive model and using more favorable assumptions, DCOPN sought to create circumstances most favorable to an applicant seeking ICU beds. Yet, the calculations still

yielded a PD 8 surplus of 21 ICU beds in 2007. Clearly, no public need for additional ICU beds exists in PD 8.

12VAC5-240-40. Continuity; system coordination for intensive care beds. A. All proposals to establish or expand general intensive care beds or cardiac care beds should provide written policies and agreements providing for transfer of patients to specialized units outside of their facility.

NVCH states that it would "negotiate formal agreements providing for transfer of ICU patients to other specialized units prior to BRMC's opening in 2006."

B. [Regards proposals to establish or expand specialized intensive care units.]

[Not applicable.]

12 VAC 5-240-50. Cost. A. Use of underutilized beds. 1. For proposals that have a capital cost of $1 million or more, preference shall be given to applications which propose to expand intensive care or pediatric units through the conversion of existing underutilized general medical/surgical beds, or to the expansion of general medical/surgical beds through the conversion of underutilized specialty beds.

The Broadlands project proposes the conversion of four underutilized medical-surgical beds at NVCH to ICU beds at BRMC and the conversion of 14 underutilized medical-surgical beds to progressive care beds at BRMC, which would provide a complement of 16 intensive care beds and 34 progressive care beds at BRMC. NVCH's application deserves preference under this standard, but such a preference should have an effect only where a need for the beds in question has already been determined.

~~*2. No hospital should relocate beds to a new location if underutilized beds (less than 85 % average annual occupancy for medical/surgical and pediatric beds and less than 65 % average annual occupancy for intensive care beds) are available within ten miles of the proposed site of the applicant hospital.*~~

[NOTE: Pursuant to Subsection A of Section 32.1-102.3 of the Code of Virginia, on January 28, 2003, the State Health Commissioner set aside the language contained in this subsection, as indicated by the stricken through text above, finding that the language is outdated and inadequate.]

B. Reasonable construction cost. 1. The cost per square foot of new construction as well as renovation to the exiting facility should be consistent with state and regional costs for similar facilities and patient units.

The direct construction cost, per gross square foot, of Broadlands is $229. This figure compares favorably with the average figure for several recently-approved projects across Virginia. Notably, however, the total capital cost of the project, which includes equipment costs, site acquisition and preparation costs, various fees and financing costs, is $192,463,192, excluding HCA's recent cost of acquiring NVCH. This total capital cost is equivalent to over $1 million per proposed bed, which compares unfavorably to similar projects, as discussed in relation to the sixteenth statutory consideration, below.

2. Preference will be given to those proposals which identify the major source of capital as accumulated reserves.

The Broadlands proposal would be financed entirely from accumulated reserves of HCA, the parent company of NVCH and Dominion Hospital. This financing scheme warrants a preference to the proposal, to whatever extent such a preference should be operative when comparing an application for the replacement and relocation of two hospitals with two separate applications for incremental additions of acute care beds at existing hospitals.

C. Operating cost and charges. 1. The applicant should demonstrate that projected operating costs and charge structure will be comparable or less than similar facilities operating in the same planning district. 2. For projects involving an off-site replacement of beds, the applicant should, in addition to the above standard, demonstrate that the operating costs and charge structure of the proposed facility shall be comparable to, or less than continued operations at the existing facility. *3. Preference should be given to those facilities which have consistently demonstrated the highest levels of charity care as a percent of total patient revenues as reported to the Virginia Health Services Cost Review Council.*

[NOTE: The Virginia Health Services Cost Review Council no longer exists; many of its programmatic activities have been transferred to the Department of Health, which discharges this particular activity in collaboration with Virginia Health Information.]

In 2000, NVCH had the highest charges per adjusted admission and the highest costs per adjusted admission among acute care hospitals in PD 8, as shown in the table below.

Charges and Costs per Adjusted Admission in PD 8 Acute Care Hospitals, 2000

Hospital	Charges per Adjusted Admission	Costs per Adjusted Admission
NVCH (HCA)	**$19,060**	**$8,288**
Arlington Hospital	14,739	6,525
Reston Hospital Center (HCA)	12,865	5,505
Loudoun Hospital Center	12,554	7,111
Fairfax Hospital (Inova)	11,981	6,086
Alexandria Hospital (Inova)	11,834	5,827
Potomac Hospital	11,833	6,682
Mt. Vernon Hospital (Inova)	11,459	5,890
Prince William Hospital	11,037	5,690
Fair Oaks Hospital (Inova)	10,306	5,456
Average	***$12,767***	***$6,306***

NVCH asserts that "[t]he proposed consolidation of two inefficient facilities into one modern efficient facility will enable operations at lower costs and charges. Consequently, the projected operating costs and charges structure at BRMC will be comparable to other hospitals in PD 8." While benefits from consolidation are likely, NVCH has not demonstrated the magnitude of any expected reduction in costs incurred and charges imposed by NVCH. In its report on the present application, HSANV observed that

> HCA [the ultimate parent corporation of NVCH] has long been, and remains, a high-cost, high charge provider that provides relatively little charity care. Standardized operational data show that HCA hospitals statewide, including those operated in Northern Virginia, are disproportionately represented among those with the highest charges, the highest cost-to-charge ratio (*i.e.*, a higher mark-up) and the least charity care.

As shown in the following table, NVCH provided a level of charity care equivalent to 0.05 percent of its gross patient revenues in 2000, while the average level of such care provided by hospitals in PD 8 was 1.67 percent. NVCH asserts, however, that BRMC "will adopt the charity care policy currently in practice at HCA's other Northern Virginia hospitals to provide medical services to those that cannot afford them." HSANV observes that "HCA has long been, and remains, a high-cost, high-charge provider that provides relatively little charity care," despite its recent decision to adopt a policy addressing this. NVCH deserves no preference based on its record of providing charity care.

Charity Care Provided by General Acute Care Hospital Systems in HPR II, 2000

Hospital	Total Gross Patient Revenue	Charity Care at 100 Percent of the Federal Poverty Level	Payments to or Receipts from ( ) the Indigent Care Trust Fund	Net Charity Care at 100 Percent of the Federal Poverty Level	Net Charity Care as a Percentage of Gross Patient Revenues
Arlington Hospital	$345,272,112	$10,400,591	$ 0	$10,400,591	3.01
Inova Mt. Vernon Hospital	184,434,625	4,303,407	(544,363)	3,759,044	2.04
Inova Fairfax Hospital	954,529,954	19,137,651	(584,806)	18,552,845	1.94
Potomac Hospital	152,333,615	2,299,547	200,967	2,500,514	1.64
Alexandria Hospital	304,743,200	4,707,561	(672,267)	4,035,294	1.32
Prince William Hospital	171,692,056	2,128,989	0	2,128,989	1.24
Inova Fair Oaks Hospital	179,738,396	1,873,427	115,727	1,989,154	1.11
Loudoun Hospital Center	123,756,000	1,358,000	0	1,358,000	1.10
Reston Hospital Center	204,521,739	715,843	59,171	775,014	0.38
Northern Virginia Community (NVCH)	**108,732,279**	**52,986**	**0**	**52,986**	**0.05**
				PD 8 Median	***1.28***
				PD 8 Average	***1.67***

12 VAC 5-240-60. Quality; accreditation and compliance with chapters. A. The applicant should provide assurances that the proposed facility or units will be designed, staffed, and operated in compliance with applicable state licensure chapters. B. The applicant should agree to apply for accreditation with the Joint Commission on Accreditation of Healthcare Organizations [JCAHO] or other appropriate accreditation organization.

NVCH has provided assurance that the facility will comply with applicable licensure requirements and regulations, and with applicable accreditation standards of JCAHO.

3. The relationship of the project to the long-range development plan, if any, of the person applying for a certificate.

NVCH states that the BRMC application

> effectively constitutes [BRMC's] long range facility plan. The proposed replacement and relocation are consistent with the long range strategy for consolidation of two older facilities into a single modern hospital with resultant operational and functional efficiencies.

NVCH has an interesting history of ownership. In the early 1960s, a group of local physicians developed the facility as a for-profit medical-surgical hospital, then known as Northern Virginia Doctors Hospital. In 1983, the Hospital Corporation of America (HCA) purchased the facility, and in 1987, sold it to Healthtrust, Inc., "as part of a major divestiture," according to NVHSA.

On May 7, 2002, Northern Virginia Community Hospital, L.L.C., informed the Department of Health that it intended to purchase NVCH. On June 21, 2002, Ventas Realty, Limited Partnership, a Delaware limited partnership, conveyed NVCH to Northern Virginia Community Hospital, L.L.C. NVCH's application to replace and relocate the hospital to Loudoun County, filed on July 1, 2002,

The facts outlined above are consistent with the theory that HCA was familiar with the challenges posed by the physical plant of NVCH and that it completed the task of acquiring ownership of NVCH in 2002 in order to have a hospital to relocate to Loudoun County – the second fastest growing U.S. county, the eastern portion of which is an area of considerable development. An application to replace and relocate a hospital within a planning district may be approved only after a demonstration that it complies with the law, but the task of showing the existence of numerical need for the addition of acute care hospital beds according to the computational methodologies contained in 12 VAC 5-240-30 is not necessary in such a case.

4. The need that the population served or to be served by the project has for the project, including but not limited to, the needs of rural populations in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

The population of PD 8, especially Loudoun County, has experienced substantial growth in recent years. Loudoun County is the fastest growing county east of the Mississippi River and the second fastest growing county in the nation. It grew by 83,470 or 95.9 percent in the 1990s an estimated 13 percent in the last 15 months, and Loudoun County's government expects it to be home to 303,807 residents by 2010. HSANV notes that northern Virginia's population is "not aging rapidly," indicating a continuation of the relatively low level of hospital utilization, despite a continued increase in overall population. The 2000 U.S. Census shows that the minority population of PD 8 has increased to 35 percent of the total, with this portion almost evenly split among African-Americans, Asians and Hispanics. The minority population is fairly evenly distributed across the area, with only Loudoun County and Falls Church (an independent city located between Fairfax and Arlington counties), having small minority populations.

As discussed above in relation to 12 VAC 5-240-30, DCOPN has determined that, using the computational methodologies contained in that section of the SMFP, PD 8 will have a surplus of 155 medical-surgical-pediatric beds and 169 intensive care (ICU) beds in 2007, based on the inventory of existing and approved beds. Using an alternative methodology designed and intended to review the four applications in the most favorable light, DCOPN determined that PD 8 will have a surplus of 103 medical-surgical-pediatric beds and 21 intensive care (ICU) beds in 2007, based on the inventory of existing and approved beds. No numerical need for additional acute care beds exists in PD 8.

NVCH argues that Dominion is obsolete and that modern methods of psychiatric care make freestanding psychiatric hospitals, such as Dominion, less than ideal. Consolidation of Dominion with an acute care hospital would incur several substantial benefits that reflect current modes of medical practice, including access to full time medical staff, and pharmacy and laboratory services. NVCH stated at the IFFC that free-standing psychiatric hospitals, such as Dominion, have probably not been designed and built in the U.S. since the early 1980s.

A proposal to relocate a psychiatric hospital and consolidate it with an acute care hospital must, however, also be reasonable in, among two other things, its proposed location. Removing these beds from Fairfax County (where Dominion sent over 60 percent of its discharges in 2001), moving them many miles from Alexandria and Arlington (where Dominion sent 14.4 percent of its discharges that year) and locating these psychiatric beds in eastern Loudoun County, (where Dominion sent only 8.8 percent of its discharges) would create a geographical imbalance and clearly involves an unreasonable geographic relocation.

5. The extent to which the project will be accessible to all residents of the area proposed to be served.

BRMC would be geographically accessible to the residents of PD 8. NVCH has provided statements indicating that services will be available to all persons without regard to their ability to pay, although it has the lowest level of charity care of any hospital in PD 8, as discussed above. Notably, HSANV observes that "[t]he principal barrier to health care in Northern Virginia is economic, not distance or travel time. . . . [w]ith 11 percent of the . . . population uninsured in early 2001. . . ." As discussed above, in 2000, NVCH provided a level of charity care equivalent to only 0.05 percent of its gross patient revenue, while the median level among PD 8 hospitals was 1.28 percent and the average level was 1.67 percent.

6. The area, population, topography, highway facilities and availability of the services to be provided by the project in the particular part of the health planning region in which the project is proposed, in particular the distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

Northern Virginia, or PD 8, is a heavily populated area. The entire area – not just Loudoun County – has experienced extraordinary development and population growth through the 1980s and 1990s, with some continued growth projected, but predictions of its magnitude vary. PD 8 covers only 1,314 square miles, but its population, totaling 1,815,197 in 2000, comprises 25 percent of the total population of Virginia. Northern Virginia has a relatively young population, with only 7.47 percent of

its population being age 55 or over, while statewide, 11.19 percent of the population is 55 or over. HSANV notes that recent projections of increases in the elderly population have proven too high and predicts that PD 8's general population will not age rapidly. Portions of PD 8, including western Loudoun County, are rural; most of the growth in Loudoun has been concentrated in its eastern portion, with the county's government attempting to limit development of, roughly, its western two-thirds through recent planning efforts. The median family income in PD 8 is the highest of any planning district in Virginia. Major employers in the area include the federal government, and high technology and other service-related industries.

PD 8 is traversed by numerous U.S. and state highways as well as three interstate highways that have heavy traffic congestion, frequently causing considerable travel delays. Such delays, along with relatively high levels of hospital utilization, contribute to the frequency of rerouting emergency patients and delays in care. Currently, 288 hospital beds are approved but unbuilt in PD 8; a total of 69 of these will be at RHC and IFOH, both located in western Fairfax County and close to eastern Loudoun County, while 42 additional approved beds will be at LHC. Thirty-seven of these beds, LHC stated in a post-IFFC filing, are expected to be operational "between January and March 2003."

NVCH argues that BRMC would improve accessibility for residents of Loudoun County who currently have had difficulty accessing services at LHC due to emergency medical reroutes and the distance residents in the western portion of the county must travel for medical services. LHC is currently in the process of opening a full service emergency room at its Leesburg facility, which should readily accommodate medical emergencies in the county and stem the need for reroutes.

NVCH contends that

> [t]he number of hospital beds in Loudoun County is not keeping up with the current population explosion. Loudoun County has only 0.8 hospital beds per 1,000 residents compared to the statewide average of 2.9 beds per 1,000 residents. . . . Loudoun County is the only part of PD 8 that is experiencing a hospital bed shortage. [PD 8] has an average of 1.5 [1.44 according to the October 2002 report from the Loudoun Health Care Task Force] beds per 1,000 residents compared to the 0.8 hospital beds per 1,000 Loudoun County residents. (HSANV Staff Report, 10) [An apparently erroneous citation.] There is a serious maldistribution of hospital capacity in the region, because 70% of the region's licensed hospital capacity is located in the northeastern quadrant of PD 8. While there is a hospital bed shortage in Loudoun County, there is a bed surplus in the northeastern region of PD 8 where the existing NVCH facility is located.

Whether Loudoun County continues its explosive growth is a debatable issue, and the county has undertaken steps to limit development, but the sort of analysis proposed by NVCH runs counter to sound health planning principles. According to the associate director of NVHSA, who testified at the IFFC, analyzing bed need and usage in terms of a desired number of beds per thousand population, on a county-by-county basis " . . . becomes absurd from our perspective . . .," adding that

> [e]ither that's the basis for making decisions on applications or else there's some other rationale that's based on actual utilization services, migration patterns, a whole host of

> things. . . . If you use it [a county-by-county approach], in essence what you are saying then is that every county . . . should have the same bed to population ratio regardless of what the use rate is per population within that area, regardless of what the migration patterns are, and that seems to us to be something that is on its face absurd, . . . it does not reflect reality, it does not reflect either the need or demand for services, it does not reflect the medical trade patterns or a host of other things. . . . [T]hat report [the October 2002 task force report] says no patient, no resident of Loudoun County should receive hospital care outside of Loudoun County.

HSANV's associate director testified further regarding that agency's concerns over the procedure and substance of the report, stating generally that it is "so flawed as to undermine and make it irrelevant to a decision as to how many beds should be permitted in Loudoun County."

The SMFP contains a computational methodology designed to respond sensitively to population-based need for additional acute care hospital beds and intended to balance and distribute such resources fairly and appropriately within an identified planning district. *See* 12 VAC 5-240-30. Virginia's planning district system has been relied upon for over thirty years to partition the state into useful components for rational planning in a host of areas. The planning district system reflects geographic, social and market-based similarities, connections and patterns among communities, counties and cities, and remains the primary system of configurations for health planning purposes.

Because the three applications competing and reviewed with the present one clearly propose additional acute care beds, and because the application to establish BRMC, in effect, proposes to add 16 beds that could be devoted to acute care purposes, DCOPN employed the SMFP methodology to gauge the need for acute care beds in PD 8. DCOPN found that PD 8 will have a surplus of 155 medical-surgical and pediatric acute care beds in 2007 and a surplus of 169 ICU beds in 2007.

DCOPN observed that the SMFP methodology may not be

> . . . the most reasonable and suitable method of projecting future demand for medical/ surgical plus pediatric inpatient days in PD 8 [a constituent component of the methodology]. Hospital utilization data for PD 8 over recent years show[] that total hospital inpatient days in PD 8 *declined* about nine percent from 1992 until 1996, during which time population *increased* about eight percent. However, from 1996 through 2001, total hospital inpatient days in PD 8 increased about 4.4 [percent] per year, while population increased about 2.2 [percent] per year. Clearly, a constant use rate of hospital inpatient days per unit of population, as specified, by the SMFP, is not now a good assumption or basis for planning. [Emphasis in original.]

In order to consider prevailing circumstances in a light most favorable to NVCH's application, and the three competing ones, DCOPN sought to assuage the effect of the computational methodology set forth in regulation and to devise a computational model that compensates for observed inconsistencies in available data. Under no regulatory requirement to do so, DCOPN devised and applied an alternate methodology to project need for medical-surgical and pediatric beds which attempts to compensate for the statistical anomaly of declining inpatient days by assuming a reasonable increase of 0.3 percent in

hospital discharge rates through 2007 and a constant, average length of stay for hospital inpatients. The resulting projection of medical-surgical and pediatric inpatient days for 2007 is 3.4 percent greater than that resulting from use of the SMFP methodology.

Despite this modification, DCOPN still projects a surplus of medical-surgical and pediatric beds in PD 8 in 2007. The modified surplus is smaller, totaling 103 rather than 155 beds. Regardless, this surplus constitutes over 6.1 percent of the expected inventory of such beds in 2007.

Although the number of hospital beds in Loudoun County, in relation to its population, is not as high as the reported state average, hospital beds in other localities across PD 8 remain available and are routinely used by Loudoun residents. This reality comports with the law and regulation of public need. Focusing on the number of hospital beds within a particular county's borders, although easily grasped by the popular mind, to the exclusion of numerous other compelling, and legally controlling, considerations is an exercise in disproportionate emphasis and an abandonment of sound health planning principles.

7. Less costly or more effective alternate methods of reasonably meeting identified health service needs.

NVCH argues that "[b]oth NVCH and Dominion Hospital are obsolete facilities that can no longer provide high quality care in an operationally and functionally efficient manner due to the deteriorating physical plants at both facilities. NVCH was constructed in 1960, and Dominion in 1968. Currently, both facilities are encountering increasing problems meeting building code and ADA requirements." The physical plants of NVCH and Dominion are in need of substantial upgrades, as DCOPN observes. HSANV has encouraged HCA to replace Dominion for "nearly two decades." NVCH presented considerable evidence at the IFFC regarding deficiencies and circumstances that fail to comport with modern needs and expectations relating to hospital activities.

NVCH asserts that hospitals such as NVCH and Dominion have a so-called "right to replace" themselves. Restated in a manner consistent with Virginia law and sound principles of health planning, a hospital has an *opportunity, in an administrative proceeding, to demonstrate that it is obsolete, and if so, to propose a replacement project that is reasonable in scope, location and cost, which may or may not involve relocation*. This accurately portrays the perspective with which the Commissioner has applied the law and reviewed at least a half dozen replacement and relocation projects in recent years.

LHC, a party to the administrative proceeding at which the present application was reviewed by virtue of having filed a competing application, presented evidence at the IFFC through the testimony of an architect with particular experience in renovating and rebuilding acute care hospitals on-site and who had visited NVCH in 2002. LHC contends that the site upon which NVCH is presently located contains between nine and ten acres available for a replacement hospital facility and support structures.

NVCH and LHC presented conflicting evidence regarding the amount of land available on the NVCH campus for development. At the public hearing on the present application, NVCH's architect identified the campus as comprising 11.6 acres, and stated that the site includes a wetlands mitigation

area and historical preservation restrictions, leaving "only about four and a half acres of usable space." At the IFFC, the architect testifying on behalf of LHC, stated that, upon reviewing relevant information, he believes the NVCH site is "approximately 15.75 acres, and about six and a half of these acres was designated toward a scenic easement, and any reference to wetlands is somewhat incorrect." The record in this matter includes a November 5, 2002, memorandum from an attorney in Arlington, submitted by LHC, stating that, "[a]ccording to County records, the [NVCH] site is comprised of 15.75 acres." LHC also submitted an excerpt from an application for a COPN, submitted in 1992 or 1993 to renovate NVCH, then known as Northern Virginia Doctors Hospital, which identified the "size of the site" as being 15.75 acres. LHC's architect testified at the IFFC that the amount of land available for development at NVCH is not 4.5 acres, but includes an additional five acres, even with the scenic easements "completely subtract[ed] out," leaving between nine and ten acres available for development.

Certainly the renovation or replacement on-site of NVCH, combined with a relocation of the psychiatric beds at Dominion either to the campus of NVCH, or to RHC, would be inconvenient and somewhat disruptive to ongoing health care activities at NVCH, but it has not been proven dispositively to be unreasonable. (In 1983, HCA proposed and the Commissioner approved the replacement and relocation of Circle Terrace Hospital and Dominion to Reston in western Fairfax County; during review of the application, HCA removed the aspect of the proposal involving the relocation of Dominion's beds to Reston.) Renovation of NVCH or its replacement on-site would keep NVCH in the most densely populated area of PD 8 and keep Dominion's psychiatric beds nearer the center of northern Virginia's population and the greatest number of its discharged patients, without presenting a threat to the future viability of LHC.

8. The immediate and long-term financial feasibility of the project.

DCOPN found

> . . . little reason to doubt that Broadlands' parent organization, HCA, could and would sustain this facility [BRMC] to whatever extent might be necessary. In that sense, the project is financially feasible. Whether and when it would prove to be a financially positive investment is not easily determined with any degree of confidence. If Broadlands achieves the second-year occupancy of 82% projected in its application, the project would be financially successful right from the start.

DCOPN, however, found no need for acute care beds in PD 8, and doubts

> that its projection of 82% occupancy in the second year would be achieved. However, many hospitals, especially for-profit hospitals, are financially successful in Virginia at much lower occupancy ratios. In short, [DCOPN] believe[s] that the Broadlands project is financially feasible and would also be financially positive for its investors in a reasonable period of years.

Notably, NVCH stated at the IFFC that HCA has "improved the financial stability of [NVCH] and hope[s] to continue to do so . . . [and has] place[d] both facilities [NVCH and Dominion] under central management."

9. The relationship of the project to the existing health care system of the area in which the project is proposed; however, for projects proposed in rural areas, the relationship of the project to the existing health care services in the specific rural locality shall be considered.

The proposed project poses an increase in market concentration in the existing health care system located in Loudoun and western Fairfax counties, likely competition for both a limited patient pool and a limited labor pool in western PD 8, and a regional imbalance in psychiatric services. While HCA has the financial resources to sustain operational losses for a period of years, LHC – an "essential community hospital," as designated by HSANV, may not be in a similar position. DCOPN recognizes that LHC, which has served Loudoun County since 1917, "appears to have turned around a dire financial situation [in recent years] but remains in the fragile early stages of financial recovery." Both DCOPN and HSANV share the concern that BRMC would have a devastating effect on LHC.

The introduction of BRMC, assuming it would achieve projected levels of utilization, would inject harmful competition into the area. BRMC would share a substantial, overlapping service area with LHC, IFOH and its sister facility, RHC, also owned by HCA. While a proposed relocation project may offer the prospect of beneficial competition, the proposal to establish BRMC, along with RHC's presence and impending expansion, would inject harmful competition and increase market concentration in western Fairfax County and in Loudoun County by making HCA the dominant system in the area. If the Broadlands project were approved and the LHC and IFOH projects were denied, HCA's resulting two hospitals – BRMC and RHC, would have 54.6 percent of the acute care hospital beds in the Loudoun and western Fairfax counties service area, while IFOH would have 23.8 percent of the beds LHC would have 21.6 percent of the bed inventory, as the following table shows.

Beds Located in and Serving Loudoun County and Western Fairfax County

Applicant Hospital System	Beds Existing at RHC	Beds Proposed at BRMC	All Beds if the BRMC Application is Approved	Percentage of Total Beds in the Area
HCA	187	180	367	54.6
Other Hospitals	Existing Beds			Percentage of Total Beds in the Area
Inova Fair Oaks			160	23.8
LHC			145	21.6
		Total Beds	672	

NVCH projects that BRMC would have 148 patients a day by 2007, with 91 of those being non-psychiatric. Most of the 91 acute care patients would probably otherwise go to LHC. Approval of 60 beds last year at RHC was based in part on the representation by HCA that those beds would serve a high

percentage of the growing population in eastern Loudoun County. So, if BRMC meets its target level of use in 2007, LHC would surely experience a significant decrease in patient volume. HSANV predicts that "[i]t would be all but impossible for [LHC] to survive as an independent hospital if that reduction in use were to occur. If both hospitals [BRMC and LHC] operated at losses, HCA would have the corporate resources to cover losses at [BRMC], but, as a local non-profit, [LHC] would not have the resources to cover extended losses. . . ." LHC submitted a letter from Ziegler Capital Markets Group, predicting that, if the Commissioner approves construction of BRMC, ". . . the strong profitability that LHC has recently demonstrated would be seriously eroded . . . [and this] loss of profitability would inevitably lead to service cut backs and to other cost limited devices that would ultimately serve to reduce the prosperity of LHC and its ability to serve the residents of Loudoun County."

At the IFFC, LHC related the findings of an analysis known as the Herfindahl-Hirshman Index (HHI), generally recognized as a reliable means of assessing general market structure and indicating whether a market is distinguished by a generally competitive nature, on one end of a continuum, or by concentration of market power, on the other. Using the HHI methodology, and looking only at the numbers of acute care beds as the indicator of market share, if an infinite number of competing providers exist in a market, the HHI would equal or approach zero. If a market consists of only one provider – a monopolist, market is completely concentrated and the HHI equals 10,000. According to evidence presented by LHC, the federal antitrust agencies have several guidelines based on the HHI, with a concentration level of 1,800 in a particular market suggesting high concentration. With all existing and approved beds in Loudoun and western Fairfax considered, the HHI exceeds 3,300. If the BRMC proposal were approved, without the two remaining applications being approved, the HHI would exceed 3,800, indicating an even more concentrated market structure in this area.

NVCH refers to letters from several insurers, written between July and November 2002, as supportive of its application to build BRMC. These insurers include Trigon, CIGNA HealthCare, Kaiser Permanente, Aetna, United Behavioral Health, Options Health Care, Inc., and ValueOptions. Consideration of payments made by private insurers is crucial to gauging the financial effect of a proposed project, and the opinions of insurers must be taken seriously. In this case, however, the HHI analysis strongly suggests that payments from insurers would increase if BRMC were built. In areas of high market concentration with a meager possibility of entry into the market by additional entities, a less acute need for competition on price exists, and insurance carriers and managed care plans and, indirectly, insured persons have less opportunity to bargain with hospital systems to obtain better prices.

Analysis reveals that the letters from insurers include statements based on superficial analysis. The letter from Trigon, for example, states tersely that "[i]n general, Trigon believes that increased competition is beneficial to the community." Trigon's letter consists of one brief substantive paragraph and reveals no appreciation or understanding of the complexity involved in rationally allocating a resource as important as acute care beds and general hospitals, or of the unique circumstances prevailing in PD 8, including the large number of approved but unbuilt beds. The letter from Kaiser Permanente, while clearly expressing support for the replacement of NVCH, recognizes the "often complex and difficult issues surrounding appropriate hospital inpatient bed capacity. . . ." and concludes with the conditional statement that "[i]f HCA's request for a COPN will help ease our ability to meet the needs of our members by having readily available beds of all types, we are in strong

support of the [proposal]." The letter from CIGNA HealthCare states that CIGNA is "concerned about our ability to achieve" the goal of "negotiat[ing] contracts with providers in Northern Virginia which meet our subscribers' needs." As demonstrated by application of the HHI analysis and in consideration of the harmful effects additional competition would have on LHC, approval of BRMC would likely have the effect CIGNA apparently fears.

HSANV contends that having one hospital in Loudoun County and permitting it to develop to a desirable size and level of sophistication would serve the community interest by allowing it to provide and introduce a broader array of services. Currently, LHC and RHC are the smallest hospitals in PD 8. If BRMC were approved and developed, to occupy a service area overlapping with those of LHC and RHC, HSANV predicts that "it could be decades before there is a sizable, strong viable hospital providing comprehensive services" to Loudoun residents.

The prospect of building BRMC presents the danger of harmful competition, leading to challenges within the health care system of PD 8 and higher prices within the intended service area. This likelihood indicates that BRMC is not a reasonable project to replace NVCH, insofar as its proposed scope and location, as those two considerations have played constituent parts in past decisions of the Commissioner on proposed hospital relocations, would have a negative effect on the health care system.

10. The availability of resources for the project.

Construction of BRMC would be financed from HCA's accumulated reserves; the necessary financial resources to construct and implement BRMC, and to operate through an indeterminate initial period of underutilization, are available and adequate. Despite the national shortage of nursing staff, BRMC would likely obtain the personnel and human resources to staff its operations adequately. NVCH proposes doing this through busing its current staff 25 miles from Arlington County to the site proposed for BRMC in Loudoun County, and predicts that its existing staff would "constitute the core employees" at BRMC. The viability and effective duration of such a busing scheme is questionable and the probability that many health care staff now employed at LHC would be lured to BRMC exists. Although the human resources needed by BRMC would likely be available, its construction would complicate the ability of LHC, and perhaps other facilities, to continue enjoying the availability of resources they need to continue health care operations.

11. The organizational relationship of the project to necessary ancillary and support services.

This project proposes the relocation of all ancillary services currently provided at NVCH, excluding magnetic resonance imaging (MRI) services. Patients likely to use BRMC would have adequate access to necessary ancillary and support services.

12. The relationship of the project to the clinical needs of health professional training programs in the area in which the project is proposed.

Not applicable.

13. The special needs and circumstances of an applicant for a certificate, such as a medical school, hospital, multi-disciplinary clinic, specialty center or regional health service provider, if a substantial portion of the applicant's services or resources or both is provided to individuals not residing in the health planning region in which the project is to be located.

Not applicable.

14. The special needs and circumstances of health maintenance organizations. When considering the special needs and circumstances of health maintenance organizations, the commissioner may grant a certificate for a project if the commissioner finds that the project is needed by the enrolled or reasonably anticipated new members of the health maintenance organizations or the beds or services to be provided are not available from providers which are not health maintenance organizations or from other health maintenance organizations in a reasonable and cost effective manner.

Not applicable.

15. The special needs and circumstances for biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

Not applicable.

16. The costs and benefits of the construction associated with the proposed project.

NVCH asserts that BRMC "will be more efficient in operations and energy conservation. As a result of replacing two aging facilities at NVCH and Dominion, [BRMC] will enable significant improvements in the efficiencies realized within clinical departments and will result in the reduction of maintenance costs." The benefits of replacing obsolete facilities with state-of-the-art facilities is undeniable. In a systemic analysis, NVCH argues that its proposed replacement would rebalance hospital capacity within PD 8, enable Alexandria Hospital and Virginia Hospital Center to enjoy higher patient volumes and revenues, and stand ready to respond to a disaster at Dulles International Airport, nearby.

Many proposals promise considerable benefits, but costs associated with them – direct and indirect – often prove to be prohibitive. Although the total construction costs associated with BRMC, when set to total gross square feet of proposed space, is reasonable, the total capital costs exceed $1 million per proposed bed, and the proposal would essentially relocate the acute care facility with the highest charges and costs in PD 8 to an area where, with RHC already in western Fairfax County, HCA would have over half of the total number of acute care beds located in the proposed service area. Market concentration often leads to an upward pressure on prices, making the likely indirect costs associated with BRMC considerable.

As shown in the table below, the costs of the BRMC project are much higher than those associated with several recently-approved replacement projects projects, even when these other projects

are generously adjusted for relative inflation and regional cost differences. (NVCH provided no evidence to assist in determining the amount by which the costs of capital projects in northern Virginia typically exceed those of similar projects in other regions of the state.)

Comparison of Total Capital Cost of the BRMC Project with those of Similar and Competing Projects, Adjusted as Indicated

Recent Acute Care Hospital Replacements and One Major Renovation Approved by the Commissioner

Hospital (PD)	Year Approved	Total Beds	Total Capital Cost As Approved	Total Capital Cost Per Bed		
				A. Without Adjustment	**B. Adjusted to Present Value – Increased by 3 Percent Annually[1]**	**C. Adjusted as in B. and to Reflect a Premium for Northern Virginia of 10 Percent[2]**
RMMC[3] (15)	1993	225	$75,467,863	**$335,413**	**$437,638**	**$481,402**
LHC (8)	1995	80	54,524,000	**681,550**	**838,221**	n/a
Carillion New River (4)	1996	97	58,070,536	**598,665**	**714,838**	**786,321**
Stonewall Jackson (6)[4]	2000	45	24,487,431	**544,165**	**577,305**	**635,035**
Greensville Memorial (19)	2000	104	37,679,523	**362,303**	**384,367**	**422,804**
St. Francis (15)	2003	130	74,479,700	**572,921**	n/a	**630,213**

Currently-Competing Applications to Add Acute Care Beds at Existing Hospitals in PD 8[5]

Hospital	Total Beds Proposed	Total Capital Cost As Proposed	**Total Capital Cost Per Bed**
LHC	32	$20,935,000	**$654,219**
IFOH	40	12,706,596	**317,665**

The Proposed Replacement of NVCH and Dominion with BRMC

Total Beds Proposed	Total Capital Cost As Proposed	**Total Capital Cost Per Bed (Excluding Acquisition Cost)[6]**
180	$192,463,192	**$1,069,239**

[1] While the rise in costs associated with health care has generally outstripped inflation as reflected by the Consumer Price Index (CPI); a three-percent annual figure, used in previous COPN reviews, is generous but is used here in an attempt to reflect that reality.

[2] The costs of living, and of general products and services in northern Virginia are somewhat higher than those incurred in the rest of Virginia; this adjustment seeks to compensate roughly for that known, but difficult to calculate, reality.

[3] Regional Memorial Medical Center

[4] This project involved a major renovation, with 103,700 gross square feet (gsf) of new construction and 20,100 gsf of renovated space.

[5] In November 2002, the Commissioner approved the then-competing application of Potomac Hospital to extensively renovate that community hospital. That project involves 30 additional beds, total capital costs of $75,504,058, and a total capital cost per bed figure of $2,516,802. This project includes extensive improvements not directly represented by the number of beds approved, *i.e.*, relocation of all existing beds to a to-be-constructed four-story bed tower that will enclose 148 beds, an extensive renovation of the existing hospital structure, with asbestos abatement and physical plant and systemic updates, resulting in a high, but reasonable, cost per bed figure.

[6] This figure excludes costs associated with HCA's May 2002 acquisition of NVCH, reportedly totaling $27,500,000.

17. The probable impact of the project on the costs of and charges for providing health services by the applicant for a certificate and on the costs and charges to the public for providing health services by other persons in the area.

The BRMC application includes seven letters of support for the project from insurers. As discussed above, these letters reveal little in-depth analysis or appreciation of the complexity presented by the BRMC proposal. Neither HCA nor the insurers provide any objective evidence that the construction of the Broadlands facility would result in decreased costs to consumers and payors. Approval of BRMC would actually decrease competition in the relevant market – Loudoun County and western Fairfax County, by increasing HCA's share of the total bed inventory and, make HCA the controlling player. Reduced competition often leads to increased costs, charges and prices.

18. Improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance and cost effectiveness.

Not applicable.

19. In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities in the area similar to those proposed, including, in the case of rural localities, any distinct and unique geographic, socioeconomic, cultural, transportation and other barriers to access to care.

The facilities at both NVCH and Dominion Hospital are over 30 years old and clearly "are in need of substantial upgrades," as DCOPN observes. NVCH states that "[c]urrently, both facilities are encountering increasing problems meeting life safety code and ADA requirements. It is clear that both facilities need to be replaced, because they have become obsolete, functionally deficient, and operationally inefficient." The remainder of the analysis applied to replacement and relocation projects, *i.e.*, whether the proposed replacement is reasonable in scope, location and cost, indicates that relocating NVCH 25 miles away from its present site to an area already approved for 111 additional but unbuilt acute care beds is not a sound proposal.

20. The need and the availability in the health planning region for osteopathic and allopathic services and facilities and the impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.

Not applicable.

C. RECOMMENDATION

I have reviewed the application of Northern Virginia Community Hospital (NVCH), now owned by HCA, Inc., to replace and relocate its hospital to eastern Loudoun County, where it would become Broadlands Regional Medical Center (BRMC), within planning district (PD) 8. I have heard from counsel to NVCH in support of the application, from the Health Systems Agency of Northern Virginia (HSANV) and from the staff of the Division of Certificate of Public Need (DCOPN) who

evaluated the proposal and prepared a detailed, comprehensive report. I have considered the recommendation of the board of directors of HSANV, which recommended denial of the application.

Based on my assessment, I have concluded that the proposal does not merit approval and should not receive a certificate of public need (COPN).

The specific reasons for my recommendation include:

(i) The so-called "right to replace," touted by NVCH as an advantage held by an existing hospital, when recast and stated in a manner consistent with Virginia law and sound principles of health planning, affirms that a hospital has no such right but, rather, has an opportunity, in an administrative proceeding, to demonstrate that it is generally obsolete or unable to be renovated effectively, and if so, to propose a replacement project that is reasonable in scope, location and cost (which may or may not involve relocation), as articulated in several decisions of the Commissioner made since 1977;

(ii) The opportunity to demonstrate a purportedly necessary and reasonable replacement project ought to involve, not only a demonstration that the replacement will not harm the planning district's health system (a consideration inherent in the analysis whether the proposal is reasonable), but, ideally, a demonstration that the substantial cost involved is outweighed by some substantial benefit to the health system, such as the introduction of an element of beneficial competition;

(iii) Construction of BRMC would inject an element of harmful competition and unnecessary duplication into the health care system devoted to the intended service area – Loudoun County and western Fairfax County, which is already served by Loudoun Hospital Center (LHC), Reston Hospital Center (RHC) and Inova Fair Oaks Hospital (IFOH);

(iv) BRMC poses a threat to the continued viability and independent existence of LHC – an essential community hospital, as designated by HSANV, that has just recently reversed its financial hardships, and to LHC's ability to become a more sophisticated facility meeting its patients' health care needs;

(v) The computational methodology designed to determine the numerical need for additional acute care beds shows a surplus of 155 medical-surgical-pediatric beds and 169 intensive care (ICU) beds in 2007, based on the inventory of existing and approved beds. An alternative *ad hoc* methodology designed specifically to gauge the purported numerical need for beds in the most favorable light, shows a surplus of 103 medical-surgical-pediatric beds and 21 ICU beds in 2007. Resort to this methodology, of course, should not normally play a direct role in justifying the denial of a proposed relocation, but such a surplus indicates the imprudence of a $192 million project that offers little or no benefit in terms of improving geographic or financial accessibility;

(vi) The general population of PD 8 is not aging rapidly, limiting the effect that the elderly have on increasing the demand for acute care services;

(vii) The proposed project is not consistent with many of the applicable provisions of the State Medical Facilities Plan (SMFP);

(viii) The board of directors of HSANV has recommended denial of the proposed project;

(ix) As part of significant expansions ongoing at Inova Fairfax Hospital, IFOH, RHC and LHC, all of which serve Loudoun County and western Fairfax County, 288 acute care beds have been approved, but are as yet unbuilt or not in service, including 111 that will serve the area NVCH proposes serving through construction of BRMC, 37 of which will be in operation shortly, if they are not already;

(x) Relocation of Dominion Hospital to eastern Loudoun County would remove that facility from the center of PD 8's population, and from Fairfax County, where Dominion sends over 60 percent of its discharges, creating a regional imbalance in the provision of psychiatric care;

(xi) The total capital cost associated with the BRMC proposal exceeds $192 million, equivalent to over $1 million per acute care hospital bed;

(xii) HCA, the ultimate parent corporation of NVCH, has a history of high charges and little charity care, and NVCH provided a level of charity care equivalent to only 0.05 percent of its gross patient revenues in 2000, while the average level for hospitals in PD 8 was 1.67 percent;

(xiii) The BRMC proposal contains no component to train, or recruit from outside PD 8, additional health care staff, including registered nurses (RNs), leading to the likelihood that it will compete for a limited pool of such staff in western PD 8, many of whom presently work at LHC, RHC and IFOH; and

(xiv) While prior decisions of the Commissioner approving proposed relocations of acute care facilities have looked generally to whether the existing hospital complies with the need-and-reasonable test noted in (i), above, the application to relocate NVCH fails to present an approvable proposal because onsite renovation or replacement has not been dispositively proven to be unreasonable, and BRMC – proposed for location 25 miles from the present site of NVCH, would be unreasonable in scope, location and cost.

Respectfully submitted,

Douglas R. Harris, J.D.
Adjudication Officer